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AN OVERVIEW OF RURAL YOUTH'S MENTAL HEALTH STATUS AND SERVICES.

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ON A NATIONAL BASIS THE MENTAL HEALTH NEEDS OF THE TOTAL POPULATION ARE NOT BEING ADEQUATELY MET, AND THE RURAL SEGMENT (ESPECIALLY RURAL YOUTH) OF THE POPULATION FARES EVEN WORSE THAN ITS URBAN COUNTERPART. FACTORS CONTRIBUTING TO THIS INADEQUACY INCLUDE--(1) LOWER INCOME, (2) SPARSITY OF POPULATION, (3) LOWER EDUCATIONAL LEVELS, AND (4) THE HIGHER COST OF PROVIDING MENTAL HEALTH SERVICES IN RURAL AREAS. EVEN THOUGH OUTPATIENT CLINICS REPRESENT THE MAJOR MODEL FOR THE CARE AND TREATMENT OF THE MENTAL HEALTH NEEDS OF RURAL YOUTH, THE HARD DATA SHOW THAT THESE FACILITIES FREQUENTLY ARE UNAVAILABLE TO THOUSANDS OF RURAL YOUTH, AND WHEN AVAILABLE OFTEN PROVIDE ONLY MINIMAL LEVELS OF TREATMENT. TO COMBAT THESE DEFICIENCIES, THE CONGRESS ENACTED COMMUNITY MENTAL HEALTH LEGISLATION IN 1964. WHEN THE FULL RANGE AND COMPLEMENT OF SERVICES AND PROGRAMS ENVISAGED BY THIS LEGISLATION ARE OPERATIONAL, IT WILL BE POSSIBLE FOR RURAL YOUTH TO DERIVE OPTIMAL MENTAL HEALTH BENEFITS. THIS SPEECH WAS DELIVERED AT THE NATIONAL OUTLOOK CONFERENCE ON RURAL YOUTH, OCTOBER 23-26, 1967, WASHINGTON, D. C., SPONSORED JOINTLY BY THE U.S. DEPARTMENTS OF AGRICULTURE, HEALTH, EDUCATION, AND WELFARE, INTERIOR, AND LABOR, OEO, AND THE PRESIDENT'S COUNCIL ON YOUTH OPPORTUNITY. (ES)

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AN OVERVIEW OF RURAL YOUTH'S MENTAL HEALTH STATUS AND SERVICES*

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One way of looking at the mental health status of the rural youth population is in the context of the larger picture of the extent of need, and of the services, facilities, funds, and personnel available for the entire population. When it is realized that on a National basis the mental health needs of the population are not being met adequately, certain of the apparent deficits and lacks in some rural areas as compared with urban ones may not be quite as alarming as when viewed outside of this larger frame of reference.

National Overview

In 1965, the latest reporting period of the National Institute of Mental Health, 950,000 Americans from all walks of life turned to more than 2,000 psychiatric clinics for help. As recently as 1960, one-fifth of the country's 3,067 counties, including 6 percent of the population, lacked organized local health services.17/

Nationally, an estimated 4 million children under the age of 14 are in need of some kind of psychiatric help because of emotional difficulties. Of these, between 500,000 and 1,000,000 children are so seriously disturbed that they require immediate psychiatric help.31/ Other estimates are that from 10 to 20 percent of school children show symptoms indicative of pathology which require at least preventive mental health services.3/ And, according to the Joint Commission on Mental Illness and Health, "there is not a single community in this country which provides an acceptable standard of services for its mentally ill children, running the spectrum from early therapeutic intervention to social restoration in the home, the school, and the community."17/

Current and future difficulties are compounded by projected estimates of children in the United States who will require treatment. Dr. Morton Kramer, of the NIMH, for example, indicates that between 1963 and 1973, increases

*The author wishes to acknowledge his appreciation to Mrs. Beatrice M. Rosen of NIMH for the date she developed and which are herein contained on the utilization of rural mental health outpatient clinics.

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of 164 percent and 70 percent are expected in the numbers of patients in the age groups under 15 years and 15-24, respectively.10/ These large relative increases are the result of sizeable growth both in the age specific resident patient rates and in the general population in these same age groups.

In recognition of the magnitude of need, during the past few years the number and variety of community settings for the care and treatment of the mentally ill have expanded at a fairly rapid rate throughout the United States. Outpatient psychiatric clinics, psychiatric facilities in general hospitals, day-care and night-care hospitals and other types of facilities are supplementing or replacing services that traditionally have been provided by mental hospitals. The outreach and catchment areas of these several facilities increasingly are extending to rural areas.

Since the passage of the Hospital Survey and Construction Act in 1946 (Hill-Burton), for example, rural medical facilities of many kinds have been greatly augmented. More than half of the new general hospitals assisted have been in communities of less than 5,000 population.6/

Today, three years after the passage of the historic Community Mental Health Centers Act, the NIMH has supported the development of hundreds of community mental health centers throughout the Nation. Soon they will be serving areas containing 43 million people. Thirty percent of the centers funded so far are located in cities of a half million or more persons; 35 percent are in cities of 50,000 to 500,000; and 35 percent are in cities of 50,000 or less, including 28 percent of the total that will serve geographic areas covering some 351 predominantly rural counties.

Thus, while mental health facilities and services for rural youth and adults where they do exist as yet are nowhere near optimal levels, the proximity to urban centers of many rural places and increasingly innovative treatment and therapeutic outpatient and clinic programs of general hospitals, mental hospitals, and community mental health centers are reducing rural-urban differences greatly in the accessibility and availability of resources.

Further, as several data indicate, in numerous areas the overall levels of living among rural people have improved in recent years and have become more similar to those of urban residents. As town and country have become increasingly interrelated, and as automobiles, electric power, and many other amenities have become generally more accessible, habits and attitudes and ways of doing and thinking have come closer together than in the past. Also, many persons work in urban areas and utilize available services while preferring to live in rural places.24/

On the other hand today, as is also the case in many urban places, there are great diversity and variance in the conditions of life, in the range of

services accessible and available, and in the physical and mental health status and related characteristics of the 55 million persons, 22 million of whom are children, who live in areas technically classed as rural.

Some Urban-Rural Differentiations

Fundamental distinctions of rural areas in comparison with urban areas are that as a general rule the populations in rural areas are sparsely settled, the dependency ratios are higher, average income, and levels of education are lower, and the costs of delivery of services, as a consequence, are higher. Also, the supplying and delivering of services in rural areas must be carried out on a different basis than in the dense urban areas.

As rural income on a per capita basis ordinarily is much lower than urban income, rural people usually have poorer housing, public utilities, schools, fewer welfare and rehabilitation services, and less access to hospitals and medical personnel than urban dwellers. In mid-1965, for example, a third of all persons living on farms, and a fourth of the rural nonfarm population were in families with a cash income below the established poverty levels.25/

Other data indicate further that the more rural the counties are, the fewer are the availabilities per 1,000 population of facilities and of most types of personnel with medical and related competencies. As examples, isolated rural counties in 1962 had the fewest available medical resources, with approximately 2 hospital beds available per 1,000 population, as compared with 3.8 for the United States as a whole.6/ Hospitals in these areas had only 1 staff member per 100,000 population, while the country as a whole had an average of 24.16/

In 1960, the number of resident physicians and surgeons per 100,000 rural people was only 52.4 compared with 161.2 for urban people.17/

In other respects, Helen Wallace has reported that children in isolated counties receive one-third less medical care than those in and near cities; also, that the mortality rate of children 5-14 is 50 percent higher in rural than urban areas, and the rate for 15-24 aged group is double.31/

From all available evidence, there is no doubt that the lack of availability of and inaccessibility to mental health resources either for the early detection and prevention of mental illness or for treatment continue to be major problems for rural persons, youth and adult. This applies to hospitals, clinics, outpatient services, doctors, nurses, and other health personnel. While, in urban communities, a variety of outpatient mental health services often are provided by agencies such as family service and child welfare agencies, and school psychological services, in rural areas the psychiatric clinic is frequently the only mental health resource available.

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Where clinics or no other formal mental health resources are available in rural areas reliance often is placed solely upon the state mental hospital which may be as many as hundreds of miles away. In the extreme cases, such as in portions of the Great Plains' area and in the Appalachian region, rural mental health services and programs continue to be nearly non-existent. As a case in point, the monumental work of the NIMH, entitled "Mental Health in Appalachia", depicts certain of the direst aspects of the problems in this region in graphic detail. There is stated that:

> There are mental hospitals in rural Appalachia, but the hospital may be separated from the person who needs treatment by 150 miles, where roads are few at best and non-existent in many places... When a psychiatric social worker actually has to climb to the top of a slate dump to find a small community in need of assistance, the time involved makes it impossible for her to help very many other people that day.18/

This report notes that there is a higher percentage of childhood disability cases--mentally retarded children or seriously handicapped children--in the Appalachian area than in any other section of the country in relation to population; and, the complexities of providing care for these children are many. There are inadequate services for checking a child's hearing and eyesight, for instance, so that some children are being classified as mentally retarded who may not be. There are also those who are so socially deprived that they are far more retarded than they would be if opportunities for education and contact with other children were available. The report states further that:

> Throughout the hills there are old people living alone in almost total isolation... Similarly isolated are psychotic children, disturbed children, epileptic children, neurotic children, and every other kind of handicapped child one can think of. They are rarely brought down from the hills. Appalachia simply does not meet the needs of sick and unfortunate children. There are neither inpatient nor outpatient facilities for them. It is almost impossible to arrange for a neurological evaluation of children who may be epileptic or have other types of brain damage, because of inadequate transportation and long waiting lists. One mother, when told to bring her child to the hospital for testing, said, 'All right, I'll go out and start hitchhiking tomorrow and we ought to be there in a few days.' She was absolutely sincere about this. She had no other way than just to take the child out to the highway and start out.

An unpublished survey pertaining to one far Western state which is largely rural reports that:

> The B's live at this time on a ranch which is 458 miles from the hospital. It is a full day's drive each way to the State hospital plus an overnight stay, meals, and other incidentals. The cash outlay necessary to make this trip is at least $50 to $60... The places where the study patients live, whether in the towns or in the rural areas, are in a sense 'community-less.' General health and welfare services are so sparse, specialist services so remote, and the general understanding about mental illness so limited that patients and families, as well as physicians, judges, ministers, educators, and others who would like to help are helpless. Communication because of distance as well as because of lack of community esprit des corps, is limited. Discouragement and frustration beget other negative attitudes. There is no generally recognized or accessable source of help for most people except through the state hospital.8/

Selected Efforts of States

In recognition of the many persistent problems, most States presently are taking steps largely through community mental health programs to extend their mental health programs resources and services to include their rural populations. In these programs, outpatient services are being provided in various ways, depending on the local circumstances. In several areas an established clinic has affiliated with a community hospital to form a center for the provision of coordinated and expanded services. In some areas, the outpatient program is established as a new service to the community in a central facility that includes all of the psychiatric services essential for continuity of patient care. In other localities, the outpatient department of the general hospital operates a psychiatric service as part of a mental health center program. The NIMH notes that whatever the arrangement, the outpatient service is a link in the center's chain of services, providing both for children and adults the variety and continuity of care they may require.13/

Idaho, for example, has three community mental health centers offering services to six of its 44 counties. Each center has the services of psychiatrist, psychologist, and social workers available either on a part- or full-time basis. Referrals are accepted from any source with no age limit.

In Colorado there are 24 Community Mental Health Clinics. Of these, 19 are all-purpose clinics, two are child guidance clinics, one is for adults only, and two clinics are parts of student health centers at universities. The 19 all-purpose clinics are located in every part of the State covering, theoretically, at least, 96 percent of the State's population. Referrals take place from schools, welfare departments,

private physicians, the clergy, and a certain number of self-referrals. Both individual treatment and group treatment are used. These clinics operate solely on an outpatient basis. In Mississippi, as in several other States, outpatient services are given to children from age 4, adolescents, and adults. There are three regional mental health centers in the State. Continued care services are given in 26 counties in the State to patients released from the hospital and their families. Other States also are developing varying community oriented approaches, dependent upon several variables such as the extent of rurality, availability of existing resources, optimal manpower utilization and available budgets.

Problems in the manpower area are pointed up by data which indicate that 2/3 of the clinics in the country are unable to obtain the services of a full-time psychiatrist. In other respects, 21 state hospitals are without a single psychiatrist, and 91 state hospitals have only one to four psychiatrists.17/

Where mental health services and programs are available to serve children in rural areas, however, the principal facility utilized is the outpatient psychiatric clinic. Several studies on rural mental health have shown that the school is the most frequent source of referral of children to these facilities. Services sponsored by these clinics, nevertheless, tend to be brief and limited, often consisting only of psychological evaluation. In the rural mental health situation the point must be stressed that account must be taken not only of the activities of professional mental health personnel, but of other resources in the community in addition, such as the services provided by general medical practitioners, public health nurses, social workers, school personnel and sheriffs.

Rural Outpatient Psychiatric Clinics

The most recent surveys of outpatient psychiatric clinics (1965) conducted by the Office of Biometry, NIMH*, in cooperation with state mental health agencies show that:

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* Data developed and analyzed by Mrs. Beatrice M. Rosen, NIMH. She notes that in evaluating the findings, it is necessary to bear in mind that: (1) clinics located in urban areas may serve the surrounding rural population. Data on the number of rural residents seen in urban facilities is not available on a Nationwide basis; and (2) clinic data for 1965 have been analyzed in accordance with 1960 Census areas. No later data of this nature is available. An outpatient psychiatric clinic is defined as an outpatient mental health service unit which has a psychiatrist who takes medical responsibility for all patients and who is in attendance at regularly scheduled hours. A "rural" clinic is defined as one located in a county in which 50 percent or more of the population lives in towns of less than 2,500 persons and where the county is not in a standard metropolitan statistical area. The designation of these counties is based on 1960 Census data.
See: Rosen, Beatrice M., "Rural Outpatient Mental Health Services for Children, 1965," unpublished NIMH, 1967.

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...In rural areas the psychiatric clinic is frequently the only mental health resource available.

...A total of 25,000 children were seen in rural clinics in 1964, only 8 percent of all children served in the United States. Nevertheless, one-third of all persons under 18 years of age lived in rural areas. (Appendix, Table 2).

...The rural clinic resources continue to fall short of recommended goals, although there has been a marked increase in available clinic resources in the United States in the last decade.

...Of a total of 2,007 outpatient psychiatric clinics in the United States in 1965, only 252 were located in rural areas. Of these 234 clinics, or less than 12 percent of all clinics in the United States, served children. (Appendix, Table 1).

...Most states had at least 1 rural clinic. (Appendix, Table 2).

(Although the Northeast and the West had relatively smaller rural populations under 18 years of age (approximately 12 percent of the total rural population in each) than did the South and the North Central regions, the Northeast had the largest number of rural clinics, 89; New York State alone had 57. In contrast, the West had only 22 or less than 10 percent of the rural facilities. The North Central and Southern Regions of the country had 60 and 63 clinics, respectively.)

...Clinics in rural areas were open less frequently than urban clinics.

Only slightly more than half the clinics were open full-time, 55 were open weekly but less than 4 days and 53 were open less than weekly. (Appendix, Table 6).

...The administration of rural clinics for children was primarily the responsibility of public agencies.

Almost 40 percent of these facilities were administered by local health departments and a third by state agencies, for the most part state mental hospitals. Independent facilities also operated more than a quarter.

(This administrative pattern differs from that found in urban areas where approximately two-thirds of the agencies operating clinics are nongovernment.) (Appendix, Table 3).

...Most rural clinics were open to all types of patients without diagnostic or service restriction.

Only 20 clinics admitted only some special diagnostic or service group. Four of these reported that only mentally retarded were served; 16 were open only to exmental hospital patients. (In contrast, in large urban areas there was a larger proportion of clinics serving only special groups, such as those restricted to juvenile court cases, severely mentally ill, or school children only.) (Appendix, Table 4).

...An estimated 22,000 professional man-hours per week were provided in rural clinics during the reporting week (week of April 30, 1965).

This represented only 5 percent of the total professional man-hours available in out-patient psychiatric clinics in the United States during that week. (Appendix, Table 1).

Professional man-hours include primarily those of the psychiatrist, clinical psychologist, psychiatric social worker and nurse. Actually, somewhat less service was provided solely to children in these rural facilities since the above figure included 1,000 man-hours provided in facilities serving adults only as well as time to adults in the clinics serving both children and adults.) Appendix, Table 1).

...The full orthopsychiatric team of psychiatrist, clinical psychologist and psychiatric social worker was found in only 60 percent of the rural clinics as compared to 80 percent in larger urban area clinics.

(Twenty percent had a psychiatrist and a social worker. Only 3 percent had only a psychiatrist and an additional 6 percent had an unfilled psychiatrist position.) (Appendix, Table 5).

From the foregoing data it is clear that rural mental health services are still very meager. This deficiency is due not only to lack of resources, but to the large proportion of part-time facilities. The Rosen data show an average annual clinic caseload of about 100 patients while that of urban clinics is well over 200. Few problems of persons with severe emotional distrubance requiring intensive or emergency treatment can be handled due to the part-time character of these facilities and their limited staffs which frequently work as traveling teams.

Summary Overview and Conclusions

In summary, the incidence, prevalence, and many other characteristics of mental illness among rural youth continue to be unknown. Since many

differences in the lifeways in rural and urban areas are disappearing, it may be hypothesized that over time distinctions in the mental illnesses in these population groups also will tend to disappear.

Presently, nevertheless, there is great variance in the life patterns of rural residents as related to farm and nonfarm residence and their occupational patterns, as examples. In this context, great variance also exists in the accessibility, availability, and quality of mental health care afforded rural youth. Factors such as their geographic residence, proximity to and the availability of urban facilities and resources, family income levels and types of services and care they receive. For example, two-thirds of all rural people live within an hour's drive of a population center of 25,000 persons or more.[24]

All available evidence shows that only a small fraction of the total rural youth--far less than one percent--receive any treatment at all in their home communities; and, for the majority of such youth, the treatment and services which are provided them are far below recommended adequate standards. While most states have at least one outpatient clinic or other public program, in several isolated, remote, depressed and low-income rural areas especially, there is evidence that there are no nearby facilities or services--public or private--either to prevent or treat mental illness among either youths or adults. Further, there are larger proportions of poor people in rural America than in the rest of the Nation. Living in pockets of poverty, thousands of children and youth are thought to be largely unreached by public and private mental health efforts. These rural poor, many of whom are also migrants, include Negroes who are principally in the South, the American Indians on reservations in many parts of the Southwest and other Western States, and the Spanish-Americans mainly in the Southwest. The National Association for Community Development recently reported that, while only 29.1 percent of the Nation's population lives in rural areas, 43.4 percent of America's poor are found there; and more than half of rural poverty is found in the South.[15]

It is reported that about half the population of hired farm-worker households consists of children under 18 years of age. Some 3 million, or 54 percent, were in households in which total family income in 1962 was less than $3,000. These 3 million young people comprise 27 percent of the 11.4 million children and youth under 18 years of age living in all households in the United States in which family income totaled less than $3,000 in 1962.[25]

The Department of Agriculture reports further that recent studies show that for 11 measures of economic, social, educational, and housing status in 14 Southern States, the socio-economic gap between the white and nonwhite population in the rural population has widened far more frequently than it has narrowed, especially in the farm population.[24] This has been true in such factors as unemployment, family income levels, educational

attainment, size of household, proportion of children in broken homes, children born per woman, crowding in housing, availability of running water, and soundness of houses. It is reasonable to conclude that children in these nonwhite families represent a sizeable population of especially high mental illness risk.

While the states through their mental and general hospitals are providing various programs and services designed to reach their rural populations, it is clear that in the aggregate rural youth presently constitute one of the largest sectors, if not the largest segment, of unmet mental health need in the Nation today.

In overview, outpatient psychiatric clinics represent the major model for the care and treatment of the mental health needs of rural youth. In the vast majority of circumstances family physicians, public health nurses, clergymen, school personnel, correctional officers, welfare workers, and others who serve at the grass roots in rural areas presently must utilize these clinics, or alternatively rely upon the large, isolated, and frequently remote state mental hospitals for referral of youth patients. Accordingly, due to the minimal services provided by clinics, even where they exist, it is clear that very little is provided rural youth in the way of prevention of mental illness. In consideration of the fact that nationally rural clinics in 1965 served only 25,000 youth, there is no question that the majority of those rural youth in the Nation who are in need of services or treatment go undiagnosed and untreated.

In capsule, the hard data on rural outpatient clinics show that these facilities frequently are unavailable to thousands of rural youth, that ordinarily and in the majority of cases, they do not treat children exclusively, and that, where they do provide a range of services, only minimal levels of treatment are offered.

By comparison with urban areas, rural clinics have shorter professional man-hours per week, less frequent schedules, and less than full complements of professional staffs. Extremely little in the way of services, as a consequence, can be oriented toward rehabilitation.

The comprehensive community mental health center legislation enacted by the Congress 3 years ago is directed towards these very large problem areas. It is hoped that, when the full range and complement of services and programs envisaged by this imaginative and far-reaching program are operational in concert with many other forward Federal-state-community strides being taken in health, education, welfare, and rehabilitation programs and services, rural youth will derive the optimal mental health facilities and services which our Nationa has the capability to provide for all its citizens.

REFERENCES

1. American Journal of Orthopsychiatry, "Mental Health Highlights", Vol. 36, No. 3, April 1966.

2. Bachmura, F. T., and Southern, J. H., "Economic Bases and Potentials of Rural Communities", National Committee for Children and Youth, Washington, D. C., September 1963.

3. Burchinal, G. L., and Cowhig, D. J., "Rural Youth in an Urban Society", Children, Vol. 10, No. 5, Children's Bureau, U.S. Department of Health, Education, and Welfare, Washington, D.C., September-October 1963.

4. Fuller, V., "Rural Poverty and Rural Development", Congressional Record-Appendix, Washington, D.C., March 5, 1965.

5. Jenkins, R. L., "Incidence of Emotional Disturbance and Mental Illness Among Rural Children and Youth", National Committee for Children and Youth, Washington, D.C., September 1963.

6. Joint Committee of the American Hospital Association and U.S. Public Health Service, Areawide Planning for Hospitals and Related Health Facilities, U.S. Public Health Publication No. 855, U.S. Department of Health, Education, and Welfare, Washington, D.C., May 1961.

7. Jones, L. W., "Problems and Special Needs of Negro Youth in Rural Areas", National Committee for Children and Youth, Washington, D.C., September 1963.

8. Kraenzel, C.F., and Macdonald, F.H., Progress Report on Study of Mental Patients in Sparsely Populated Montana, Unpublished, April 30, 1967.

9. Kraenzel, C. F., and Macdonald, F. H., A Study of Mental Patients in Sparsely Populated Montana and Its Meaning for Federal-State Cooperation, Unpublished, 1966.

10. Kramer, Morton, "Epidemiology, Biostatistics, and Mental Health Planning", Psychiatric Epidemiology and Mental Health Planning, Monroe, R., Klee, G. O., and Brody, E. G., (Eds.), Psychiatric Research Report, No. 22, American Psychiatric Association, Washington, D.C., 1967.

11. Long, A. C., Family and Community Programs for Rural Youth Under the Public Welfare Amendments of 1962, National Committee for Children and Youth, Washington, D.C., 1963.

12. Mariani, E. L., Gliva, G., and Libo, L. M., "Development of Services for Meeting Mental Health Needs Among Rural Children and Youth", National Committee for Children and Youth, Washington, D.C., September 1963.

13. McCarty, C., and Rosen B., Rural Youth in Crisis: Facts, Mythys, and Social Change,"Mental Health and Mental Health Services in Rural Communities", Burchinal, L., (Ed.), U.S. Department of Health, Education and Welfare, Washington, D.C., 1965.

14. McCarty, C., Rosen, B., and Bahn, A., "Rural Mental Health Services for Children and Youth in Out-Patient Psychiatric Clinics", National Committee for Children and Youth, Washington, D.C., September 1963.

15. National Association for Community Development, "Dimensions of Rural Poverty", reported in New York Times, January 29, 1967.

16. National Commission on Community Health Services, Health is a Community Affair, Harvard University Press, Cambridge, Mass., 1966.

17. National Committee Against Mental Illness, Inc., What are the Facts About Mental Illness in the United States?, Washington, D.C., 1966.

18. National Institute of Mental Health, Mental Health in Appalachia, Problems and Prospects in the Central Highlands, U. S. Public Health Service, Department of Health, Education, and Welfare, Washington, D.C., 1965.

19. National Institue of M ntal Health, Outpatient Psychiatric Clinics: Data on Staff Manhours, U.S. Public Health Service, U.S. Department of Health, Education, and Welfare, Washington, D.C., published annually 1959-1956.

20. National Institute of Mental Health, Outpatient Services: A Service of the Community Mental Health Center, U.S. Public Health Service, Publication No. 1578, Washington, D.C., 1967.

21. Pollack, E.S., Redick, R. W., Norman, V., Wurster, C. R., and Gorwitz, K., "Socio-economic and Family Characteristics of Patients Admitted to Psychiatric Services", American Journal of Public Health, Vol. 54, No. 3, March, 1964.

22. Rosen, B., Wiener, J., Hench, C., Willner, S., Bahn, A., "A Nationwide Survey of Outpatient Psychiatric Clinic Functions, Intake Policies and Practices", Journal of the American Psychiatric Association, Vol. 122, No. 8, February 1966.

23. Smith, M. B., and Hobbs, Nicholas, The Community and the Community Mental Health Center, American Psychological Association, Inc., Washington, D.C., June 1966.

24. U.S. Department of Agriculture, Economic Research Service, Rural People in the American Economy, Agricultural Economic Report No. 101, Washington, D.C., 1966.

25. U.S. Department of Agriculture, Poverty in Rural Areas of the United States, Agricultural Economic Report No. 63, Washington, D.C., November 1964.

26. U.S. Department of Commerce, Bureau of the Census, Estimates of the Farm Population of the United States: 1964, Current Population Reports-Farm Population, Series ERS, P-27, No. 35, Washington, D.C., June 4, 1965.

27. U.S. Department of Health, Education, and Welfare, Public Health Service, National Institute of Mental Health, Outpatient Psychiatric Clinics Data on Staff and Manhours: 1959-1965, U. S. Government Printing Office, Washington, D.C., 1965.

28. U.S. Department of Labor, Manpower Report of the President and a Report on Manpower Requirements, Resources, Utilization, and Training, Washington, D.C., April, 1967.

29. United States Senate, Subcommittee on Employment, Manpower, and Poverty, Committee on Labor and Public Welfare, Profile of Youth - 1966, Parts I and II, Washington, D.C., 1966.

30. The Evening Star, "16 Million Poor Families in Rural U.S.", Washington, D.C., January 22, 1964.

31. Wallace, H., "The Health of Children and Youth in Rural Areas", National Committee for Children and Youth, Washington, D.C., September 1963.

TABLE 1. DISTRIBUTION OF 252 RURAL OUTPATIENT PSYCHIATRIC CLINICS BY AGE GROUP SERVED, UNITED STATES, 1965 1/

Age Group Served	
Total number of clinics	252
Clinics serving children and youth	234
Children (and parents) only	41
Children and adults	193
Clinics serving adults only	18
Total number of professional man-hours per week in clinics 2/	21,876
Clinics serving children and youth	20,816
Children (and parents) only	2,433
Children and adults	18,383
Clinics serving adults only	1,060

1/ Includes clinics located in counties which were 50% or more rural in the 1960 Census of Population.
2/ Week of April 30, 1965.

TABLE 2. DISTRIBUTION OF RURAL CLINICS FOR CHILDREN AND YOUTH, AND RURAL CLINIC POPULATION BY GEOGRAPHIC REGION AND STATE, 1965 1/

Geographic Region and State	Number of Rural Clinics Serving Children & Youth	Rural Clinic Population under 18 Yrs. Number	Rural Clinic Population under 18 Yrs. Percent of Total Clinic Pop. under 18 Yrs. 2/
Total United States 3/	234	25,004	8.4
Northeast	89	8,705	6.0
Connecticut	2	102	1.9
Maine	1	90	12.6
Massachusetts	3	279	2.4
New Hampshire	3	522	30.0
New Jersey	3	654	4.3
New York	57	6,380	6.9
Pennsylvania	14	678	4.1
2 other States	6	-- 4/	-- 4/
North Central	60	7,231	12.3
Iowa	9	928	24.8
Kansas	5	287	9.1
Michigan	5	1,324	9.0
Minnesota	10	2,337	41.2
Missouri	6	254	6.2
Ohio	6	899	7.4
Wisconsin	8	1,202	20.6
5 other States	11	-- 4/	-- 4/
South	63	6,905	11.3
Alabama	3	178	5.5
Florida	2	321	3.2
Georgia	1	5	0.2
Kentucky	7	430	14.1
Louisiana	5	703	10.9
Maryland	11	970	17.7
Mississippi	2	287	30.9
North Carolina	18	2,417	39.6
South Carolina	4	987	48.0
Tennessee	2	307	8.5
Virginia	2	117	1.8
West Virginia	4	183	16.1
5 other States	2	— 4/	-- 4/
West			

(Continued on following page)

TABLE 2. (Continued)

Geographic Region and State	Number of Rural Clinics Serving Children & Youth	Rural Clinic Population under 18 Yrs. Number	Percent of Total Clinic Pop. under 18 Yrs. 2/
West	22	2,163	6.5
California	7	1,032	5.5
Colorado	3	280	6.4
Hawaii	1	110	10.6
Nevada	1	174	34.3
Oregon	4	527	13.2
Wyoming	1	40	2.1
7 other States	5	-- 4/	-- 4/

1/ Includes clinics located in counties which were 50% or more rural in the 1960 Census of Population.
2/ Excludes rural children who are seen in urban clinics.
3/ Estimated figures for clini in some states.
4/ Data not available, estimat not possible.

TABLE 3. AUSPICES OF RURAL OUTPATIENT PSYCHIATRIC CLINICS SERVING CHILDREN AND YOUTH, UNITED STATES, 1965 1/

	Total	State					
		Mental Hospitals	Other Agencies or Institutions	Local Health Depts.	Other Hospitals	Other: (schools, courts, etc.)	Independent facilities
No.	234	66	7	89	4	2	66
%	100.0	28.2	3.0	38.0	1.7	0.9	28.2

TABLE 4. SPECIAL GROUPS SERVED IN RURAL OUTPATIENT PSYCHIATRIC CLINICS SERVING CHILDREN AND YOUTH, UNITED STATES, 1965 1/

	Total	No Special Group Served	Service restricted to a special group			
			Mentally Retarded	Ex-mental Hospital patients	Court	Other
No.	234	214	4	16	--	--
%	100.0	91.5	1.7	6.8		

1/ Includes clinics located in counties which were 50% or more rural in the 1960 Census of Population.

TABLE 5. STAFFING PATTERNS OF RURAL OUTPATIENT PSYCHIATRIC CLINICS SERVING CHILDREN AND YOUTH UNITED STATES, 1965 1/

	Number	Percent
Total Number	234	100.0
Staffing Pattern		
Psychiatrist, clinical psychologist, psychiatric social worker 2/	142	60.7
Psychiatrist and clinical psychologist 2/	17	7.3
Psychiatrist and Psychiatric social worker 2/	49	20.9
Psychiatrist and "other" staff	5	2.1
Psychiatrist only	7	3.0
Psychiatrist position unfilled	14	6.0

1/ Includes clinics located in counties which were 50% or more rural in the 1960 Census of Population.

2/ With or without "other" staff, such as medical personnel, nurses, therapists, and technicians.

TABLE 6. CLINIC SCHEDULE OF RURAL OUTPATIENT PSYCHIATRIC CLINICS SERVING CHILDREN AND YOUTH, UNITED STATES, 1965 1/

	Number	Percent
Total Number	234	100.0
Schedule		
Full-time (35 hours or more per week)	124	53.0
Part-time (less than 35 hours per week)	110	47.0
Weekly		
4 to 7 days a week	126	53.8
Less than 4 days a week or by appointment	55	23.5
Not Weekly		
At least once a month	41	17.5
Less than once a month	6	2.6
Appointment only	6	2.6

1/ Includes clinics located in counties which were 50% or more rural in the 1960 Census of Population.

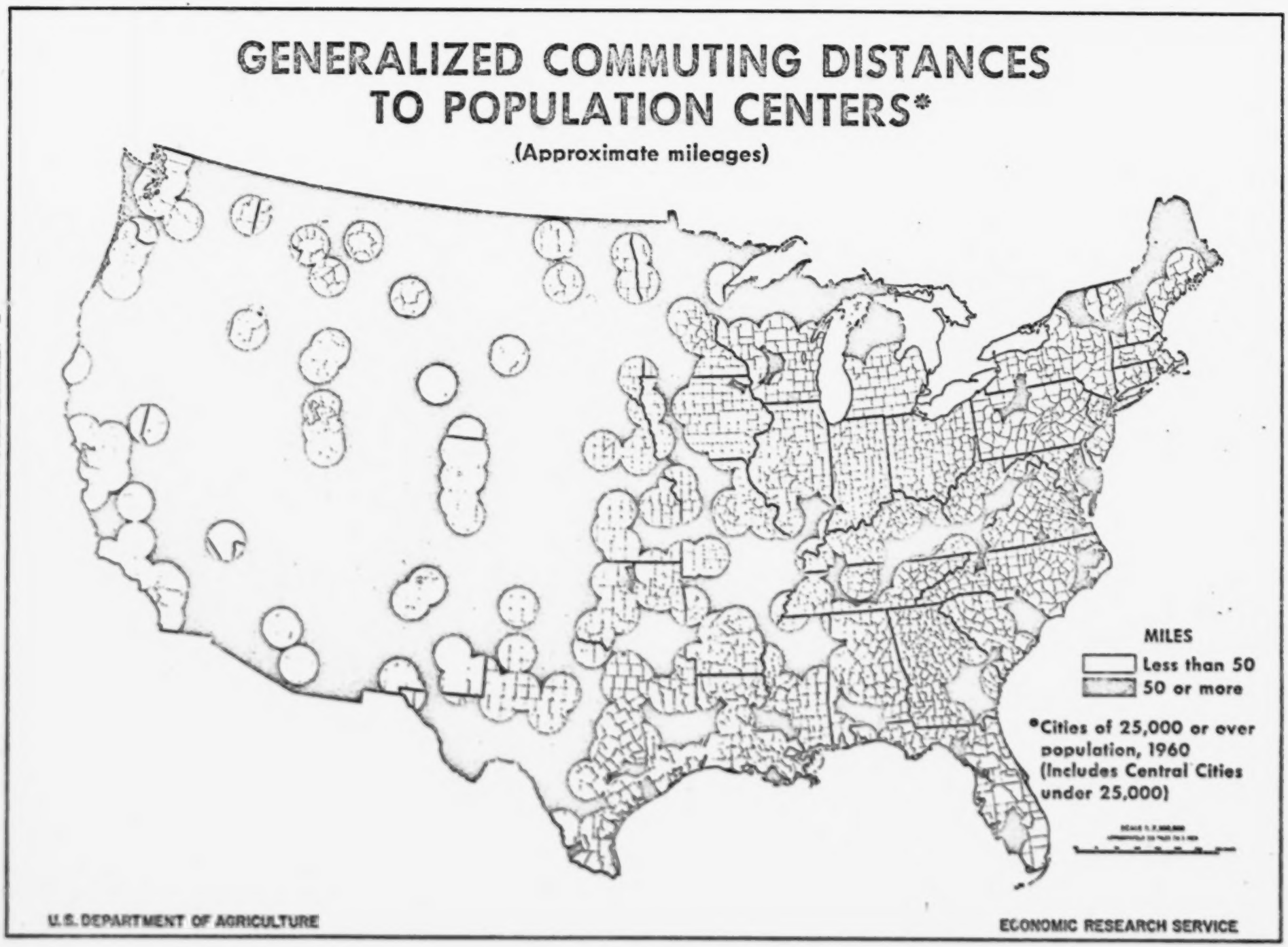
GENERALIZED COMMUTING DISTANCES
TO POPULATION CENTERS*
(Approximate mileages)
MILES
Less than 50
50 or more
*Cities of 25,000 or over population, 1960 (Includes Central Cities under 25,000)
U.S. DEPARTMENT OF AGRICULTURE
ECONOMIC RESEARCH SERVICE

Figure 1

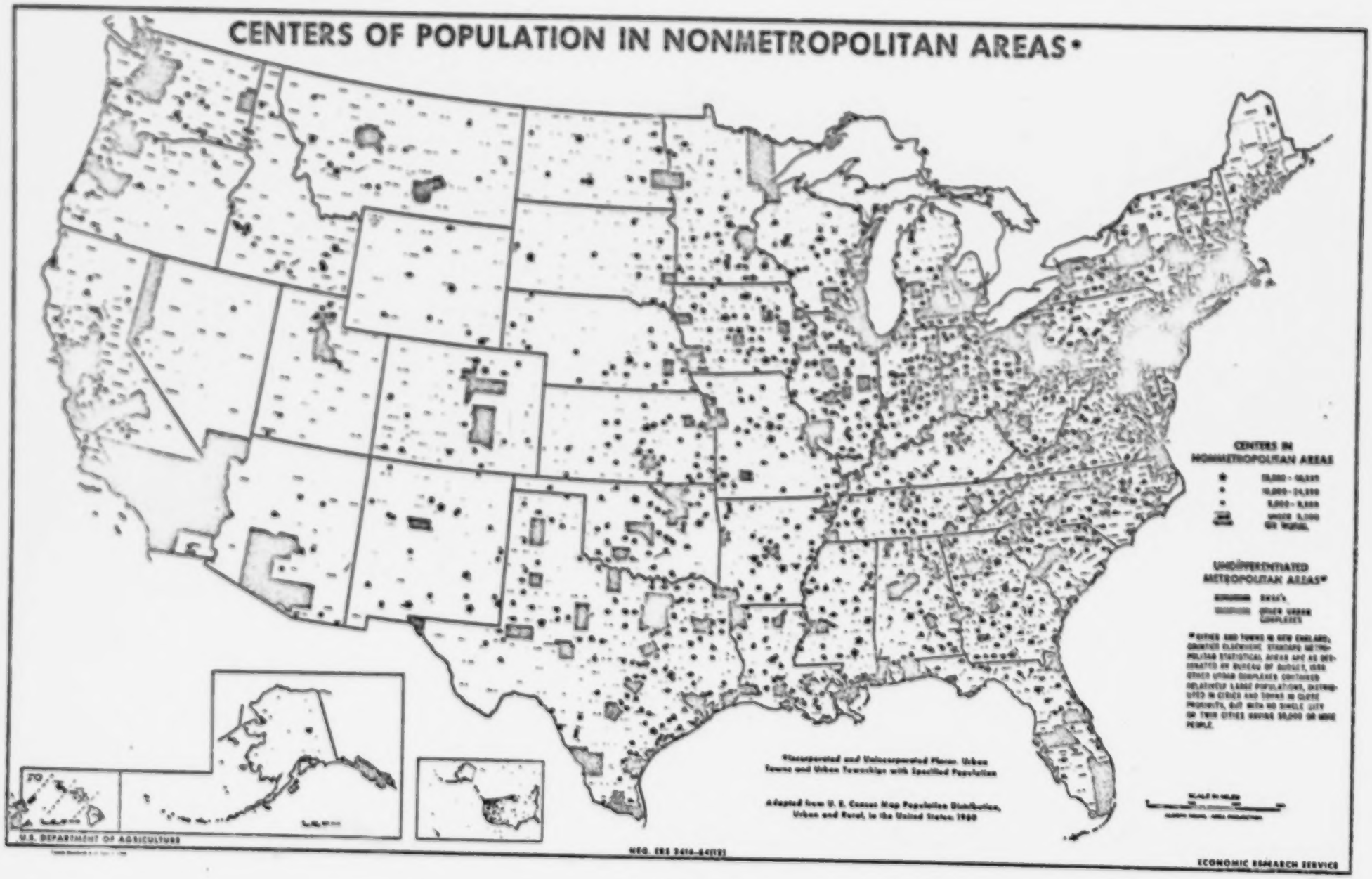
CENTERS OF POPULATION IN NONMETROPOLITAN AREAS•
CENTERS IN NONMETROPOLITAN AREAS
UNDIFFERENTIATED METROPOLITAN AREAS*
*Unincorporated and Unincorporated Places: Urban Towns and Urban Townships with Specified Population
Adapted from U. S. Census Map Population Distribution, Urban and Rural, in the United States: 1960
U.S. DEPARTMENT OF AGRICULTURE
ECONOMIC RESEARCH SERVICE

Figure 2